

Schizoaffective Disorder, Schizophreniform Disorder, and Brief Psychotic Disorder

There are three disorders in addition to schizophrenia listed in the fourth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) in the section "Schizophrenia and Other Psychotic Disorders." The first, schizoaffective disorder, is a complex illness that has changed significantly over time. In its simplest definition, it is presently conceived as an illness with coexisting, but independent, schizophrenic (psychotic) and mood components. Schizoaffective disorder is seen primarily as part of a schizophrenia spectrum rather than an equal hybrid of mood and schizophrenia disorders.

Schizophreniform disorder is a diagnosis that assumes another will replace it after 6 months. Most cases of schizophreniform disorder progress to either schizophrenia or schizoaffective disorder, with some cases re-diagnosed as a non-schizophrenia spectrum illness (i.e., schizotypal or schizoid personality disorders), while a few resolve completely. Finally, the diagnosis brief psychotic disorder describes an impairment in reality testing that lasts at least 1 day, but less than 1 month. All three disorders have a psychotic component, are often misunderstood, are incorrectly applied, and are not as well studied as schizophrenia, bipolar I disorder, or major depressive disorder.

SCHIZOAFFECTIVE DISORDER

As the end of the century nears great strides have been made in clarifying the diagnostic criteria for many psychiatric illnesses. However, patients often do not fall neatly into set illness criteria. There are several approaches to dealing with such patients. One is to diagnose the patient with two distinct illnesses and treat those illnesses as separate problems. Another possibility is to consider that the patient has a primary illness and symptoms of a second illness that are not as important and might even resolve when the primary illness is treated. A third approach considers that the patient suffers from a distinct blended illness with its own history, diagnosis, and treatment. This last approach best represents the current orthodoxy in the diagnosis and treatment of patients with the DSM-IV diagnosis of schizoaffective disorder. Unfortunately, this approach is not easily applied, often making the diagnosis confusing and convoluted.

Comparative Nosology

One of the difficulties in using a diagnosis that depends on not being another diagnosis is that both depend on changes in the other. Schizoaffective disorder is affected by any changes in the diagnostic criteria of schizophrenia, affective disorder, or both. As psychotic affective disorders and schizophrenia have been better distinguished, those who fall through the "diagnostic cracks" have become clearer. In the second edition of DSM (DSM-II) schizoaffective disorder was a subtype of schizophrenia and denoted patients who had any mood symptoms while meeting the criteria for schizophrenia. In contrast, the Research Diagnostic Criteria (RDC) for schizoaffective disorder allowed as few as one symptom of schizophrenia in a patient who met the criteria for a full affective disorder. The third edition of DSM (DSM-III),

influenced by studies in the United States and Great Britain, narrowed the diagnosis of schizophrenia and expanded the diagnosis of bipolar disorder. It allowed symptoms of schizophrenia to coexist with a mood disorder as long as these schizophrenic symptoms did not remain when the mood disorder resolved. Moreover, mood-incongruent psychotic symptoms could now exist in bipolar disorder. Finally, schizoaffective disorder moved from its schizophrenia subtype place to stand alone as a "psychotic disorder not elsewhere classified." The revised third edition of DSM (DSM-III-R) expanded this notion by inserting the criterion that a patient with schizoaffective disorder must meet the criteria for schizophrenia for at least 2 weeks independent of any mood syndrome.

DSM-IV has retained most of the DSM-III-R criteria but has stricter diagnostic criteria for schizophrenia. Patients must meet the symptoms of schizophrenia for at least 1 month as opposed to the previous 1-week criterion. Schizoaffective disorder is now listed in the section "Schizophrenia and Other Psychotic Disorders." The 10th revision of International Statistical Classification of Diseases and Related Problems (ICD-10) essentially describes the same disorder. The ICD-10 schizoaffective disorders describe single as well as recurrent episodes. Subtypes include manic, depressed, and mixed types. Mixed type includes a cyclic schizophrenia and a mixed schizophrenic-mood psychosis.

Epidemiology

There is no psychiatric epidemiological study of the incidence or prevalence of schizoaffective disorder in a general population. Prevalence rates for consecutive patients diagnosed in a psychiatric treatment setting are available. These numbers range from 2 to 29 percent, a potentially significant cohort requiring treatment.

Etiology

It is difficult to determine a cause of a disease that has changed so much over time. One might conjecture that the etiology of schizoaffective disorder as currently defined might be similar to the etiology of schizophrenia. Thus etiological theories of schizoaffective disorder would include some genetic and environmental causation. Molecular genetic studies of schizoaffective disorder have lagged behind recent studies of the genetics of schizophrenia and bipolar I disorder. Available family studies have reported that families of schizoaffective probands have significantly higher rates of relatives with mood disorder than families of schizophrenia probands. Similarly, these schizoaffective probands have more psychotic symptoms than families of mood disorder probands. The results of these family studies have argued that schizoaffective disorder is a unique disorder, separate from schizophrenia and mood disorders.

Possible environmental causes of schizoaffective disorder are similar to those of schizophrenia, including in utero insult (including malnutrition and viral causes) and obstetrical complications. One hypothesis considers schizophrenia to be a developmental and progressing disorder that can be seen in the development of brain dysmorphology. This includes less cortical gray matter and more fluid and fluid-filled spaces; however, no definitive study of patients with DSM-IV schizoaffective disorder has been done. One might assume that schizoaffective patients would have similar brain abnormalities, because the disorder mimics many aspects of schizophrenia.

For nearly a half century the prevailing etiologic theory of schizophrenia was the dopamine hypothesis. In its simplest description it postulates that the underlying abnormality is excess dopamine in areas of the brain, leading to psychosis. Thus, successful treatment with antipsychotics is due to their dopamine-blocking properties. With the successful use of clozapine (Clozaril) and other serotonin-dopamine antagonists, the dopamine hypothesis has been amended. Currently, a critical balance between the neurotransmitters dopamine and serotonin is believed to be important for treating schizophrenia. At the same time it is accepted that there are abnormalities of serotonin and norepinephrine in mood disorders. These theories are particularly interesting when considering underlying causes of schizoaffective disorder. Possibly this balance of dopamine and serotonin is particularly affected in schizoaffective disorder, leading to chronic psychosis and intermittent but substantial mood alterations.

Diagnostic and Clinical Features

DSM-IV Diagnostic Criteria for Schizoaffective Disorder

A. An uninterrupted period of illness during which, at some time, there is either a major depressive episode, a manic episode, or a mixed episode concurrent with symptoms that meet criterion A for schizophrenia.

Note: The major depressive episode must include criterion

A1: depressed mood.

B. During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms.

C. Symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of

abuse, a medication) or a general medical condition.

Specify if:

Bipolar type: if the disturbance includes a manic or a mixed episode (or a manic or a mixed episode and major depressive episodes)

Depressive type: if the disturbance only includes major depressive episodes

Differential Diagnosis

The psychiatric differential diagnosis includes all the possibilities usually considered for mood disorders and for schizophrenia

In any differential diagnosis of psychotic disorders a complete medical workup should be performed to rule out organic causes of the symptoms. A history of substance use with or without a positive toxicology screening test may indicate a substance-induced disorder. Preexisting medical conditions, their treatment, or both may cause psychotic and mood disorders.

Treatment

There are several extensive reviews of the treatment of schizoaffective disorder, but critical evaluation of the results of these studies is not easy. Because the operational definition of schizoaffective disorder has shifted over the last 30 years, comparing or pooling studies is impossible. The efficacy and selection of treatment for a patient under the broader (more mood disorder inclusive) DSM-II criteria may differ from that of the patient diagnosed with the narrower DSM-III-R criteria. However, there are some general recommendations for treatment. The principle rule is to treat the patient's symptoms, not the diagnostic label.

Mood Stabilizers Mood stabilizers are a mainstay of treatment for bipolar disorders and would be expected to be important in the treatment of patients with schizoaffective disorder. Few studies have examined the efficacy of mood stabilizers in schizoaffective disorder, in contrast to the extensive studies of lithium, valproate (Depakote), and to a lesser extent carbamazepine (Tegretol) in bipolar I disorder. A recent study that compared lithium with carbamazepine showed superiority for carbamazepine for schizoaffective disorder, depressive type, but no difference in the two agents for the bipolar type. In practice however, these medications are used extensively alone, in combination with each other, or with an antipsychotic agent. In manic episodes, schizoaffective patients should be treated aggressively with dosages of a mood stabilizer in the middle to high therapeutic blood concentration range. As the

patient enters a maintenance phase the dosage can be reduced to low to middle range to avoid adverse effects and potential effects on organ systems (e.g., thyroid and kidney) and to improve ease of use and compliance. Laboratory monitoring of plasma drug concentrations and periodic screening of thyroid, kidney, and hematological functioning should be performed. As in all cases of intractable mania, the use of electroconvulsive therapy (ECT) should be considered.

SCHIZOPHRENIFORM DISORDER

History

Gabriel Langfeldt, first used the term schizophreniform in 1939, at the University Psychiatric Clinic in Oslo, Norway. As originally used, this diagnosis relied on a tradition of Scandinavian psychiatry, which had identified a condition that had relatively brief and self-contained psychotic intervals. Patients recovered well and had affective and sometimes hysterical components to their illness, and the diagnosis was used to distinguish a group considered to have little relation to true schizophrenia.

Comparative Nosology

In contrast to this rather specific role for schizophreniform disorder, the current DSM-IV diagnosis has relatively little to do with the origin of the term and much more to do with the tradition of Kraepelinian schizophrenia as a chronic illness. Prior to the DSM-IV revision of this diagnostic entity, DSM-III and DSM-III-R had used this diagnosis as a "schizophrenia-in-waiting" diagnosis, with the only difference between the two diagnoses being whether the illness had lasted a total of 6 months including psychotic, prodromal, and residual symptoms. Under the DSM-III and DSM-III-R systems, the psychotic phase of the illness needed to last only 1 week, and less if treated successfully. The remainder of the 6-month-duration criteria for schizophrenia comprised residual or prodromal symptoms. Patients who had an insidious onset with prodromal symptoms preceding the onset of psychotic symptoms by at least 6 months would be given a diagnosis of schizophrenia as soon as the psychotic symptoms lasted 1 week. Those who had limited prodromal symptoms or who had sudden onset of psychosis as the first sign of illness, however, would not be diagnosed as having schizophrenia until the total period of illness reached 6 months. During what for many was a waiting period, the diagnosis of schizophreniform disorder would be used. Because of the relatively brief period of psychosis required (1 week) on the one hand and the similarity with schizophrenia on the other, this category formerly consisted of patients with potentially many types of psychoses—brief reactive psychosis, "schizophrenia-in-waiting," and true schizophreniform disorder. Unfortunately, the true schizophreniform disorder would be difficult to sort out from this diagnostic system, and relative to the other categories it is probably quite rare, although potentially important as a time-limited psychotic illness that returns to baseline functioning without residual symptoms.

The revisions of DSM-IV have made one of the above overlaps less likely—the one with brief reactive psychosis. To separate these two disorders diagnostically, the DSM-IV diagnosis for schizophreniform disorder requires a month of psychotic symptoms rather than 1 week. Further, brief reactive psychosis has changed to brief psychotic disorder because the diagnostic criteria reaction-to-a-stressor was considered too ubiquitous—but DSM-IV includes the concept as a specifier. From the other side, the diagnosis of schizophreniform has moved much closer to its parent

diagnosis of schizophrenia with the requirement for 1 month of psychotic symptoms. Although no data are currently available on the course of schizophreniform illness, the requirement for a greater duration of psychotic illness will probably make it less likely that a given patient will recover before 6 months of total illness comprising both psychotic symptoms and residual or prodromal symptoms (now referred to as attenuated symptoms) is reached.

This category now looks exactly like schizophrenia with an unanticipated full recovery before 6 months. Some data suggest that those who indeed do recover before 6 months have better 5- and 10-year outcomes. Whether this represents a separate disorder category or merely one end of a distribution of outcomes in schizophrenia is yet to be determined. There will always be the unusual patient who appears to have schizophrenia but recovers completely. They are exceedingly rare. Further, this category of illness continues to be severely hampered by a lack of research, and indeed the changing criteria for diagnosis makes it difficult to focus on this "moving target." Most data will continue to be anecdotal. ICD-10 does not have a designated schizophreniform disorder, although the concept is included in several categories. The diagnosis acute schizophrenia-like psychotic disorder describes a disorder that would otherwise be considered schizophrenia but with symptoms lasting less than 1 month. If the symptoms persist past the month, the ICD-10 diagnosis of schizophrenia should be used. There is also a subclassification for a schizophreniform psychosis manic or depressed type under "schizoaffective disorders"; however, according to DSM-IV, schizophreniform disorder is subsumed under ICD-10's category of other schizophrenia.

Another reason for having this diagnostic category is that it avoids having to use the term schizophrenia with all of its negative connotations early in the diagnostic formulation. Many families require considerable time to reconcile the future of their family member. A gradual introduction to the concept of schizophreniform disorder, with a waiting period during which the family can more realistically orient itself and learn about the illnesses in the schizophrenia spectrum may prove helpful to some. Further, because of the negative connotation of schizophrenia and the stigma currently attached to it, a diagnostic system that avoids a false-positive diagnosis of schizophrenia is desirable. A 6-month duration of illness prior to making the diagnosis of schizophrenia will eliminate virtually all false-positive diagnoses.

As noted above, schizophreniform disorder shares an overlap with schizophrenia with two exceptions: the duration of illness is from 1 to 6 months and social or occupational dysfunction is not required to meet the diagnosis, although it may occur at some point in the illness. Given the requirement of 1 month of psychotic symptoms, however, it seems quite unlikely that a person's social and occupational functioning would not be disrupted. DSM-IV describes two possible conditions for this diagnosis: (1) when a person has recovered within the 6-month period (the "pure" form of schizophreniform disorder) and (2) when a person has not had the illness long enough (6 months) to meet the diagnosis of schizophrenia. For this latter condition, the term "provisional" is used. A guide for clinicians is given as a part of the diagnosis, which should be qualified by the presence or absence of good prognostic signs. The following are listed, and two are required for the qualifier of good prognosis: (1) rapid onset of psychotic symptoms, (2) confusion at the peak of psychotic symptomatology, (3) good premorbid social and occupational functioning, and (4) maintenance of a range of affect.

As with most psychiatric diagnoses, schizophreniform disorder should not be used if substance abuse or a secondary medical condition causes the symptoms.

Epidemiology

Because of the significant change in the diagnostic criteria for schizophreniform disorder in DSM-IV, there are currently no epidemiological data from community samples.

Etiology

Because of the change in the duration of illness, most persons who fall in this category will have underlying pathologies similar to those with schizophrenia. This will certainly be true for those who carry this diagnosis provisionally while waiting for the 6-month time period to elapse before changing the diagnosis to schizophrenia. There has been ample speculation about whether "acute" schizophrenia (rapid onset, good premorbid functioning) differs from insidious-onset schizophrenia in anything more than severity of such factors as negative symptoms. A rapid and complete response to a treatment intervention may eventually help to differentiate those in this category from standard antipsychotic nonresponders. The concept that the heterogeneity of the underlying biology may be responsible for differential treatment response is not new, but it has been given increasing credibility with the advent of the serotonin-dopamine antagonists (clozapine, risperidone, olanzapine, and quetiapine). It is now probably safe to say that any set of biological, neurophysiological, psychologic or other tests will find this group of patients looking much more closely like schizophrenia than any other category. In fact, the abnormalities consistent with schizophrenia may already be present in schizophreniform disorder. One such abnormality, decreased gray matter volume, has been seen in MRI studies but to a lesser extent than in patients with chronic schizophrenia. The cause of pure schizophreniform disorder will probably not be known for a long time, because a patient group that small will be hard to study.

Diagnostic and Clinical Features

The DSM-IV criteria for schizophreniform are listed in

Schizophreniform disorder in its typical presentation is a rapid-onset psychotic disorder without a significant prodrome. Hallucinations, delusions, or both will be present; negative symptoms of alogia and avolition may be present. Affect may be flattened, which is seen as a poor prognostic sign. Speech may be grossly disorganized and confused, and behavior may be disorganized or catatonic. The symptoms of psychosis, the negative symptoms, and those affecting speech and behavior will last at least 1 month but may last longer. The patient's degree of perplexity about what is happening should be assessed, as this is a differentiating prognostic sign.

DSM-IV Diagnostic Criteria for Schizophreniform Disorder

A. Criteria A, D, and E of schizophrenia are met.

B. An episode of the disorder (including prodromal, active, and residual phases) lasts at least 1 month but less than 6 months. (When the diagnosis must be made without waiting for recovery, it should be qualified as "provisional.")

Specify if:

Without good prognostic features

With good prognostic features as evidenced by two (or more) of the following:

- (1) onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning
- (2) confusion or perplexity at the height of the psychotic episode
- (3) good premorbid social and occupational functioning
- (4) absence of blunted or flat affect

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Although the above is the typical presentation, a picture exactly resembling that of schizophrenia may also occur. In that case, the onset may be insidious, premorbid functioning may have been poor, and affect is quite blunted. The only differentiation from schizophrenia for this type of presentation will be duration of the total episode of illness. When it has lasted 6 months, the diagnosis becomes schizophrenia. In making the diagnosis in the case with insidious onset, the "attenuated symptoms" of the acute episode may have lasted for some time. If they have been present for at least 5 months and then the acute episode lasts 1 month, the diagnosis of schizophrenia is appropriate, without a prior diagnosis of schizophreniform disorder.

In the typical form of the disorder, the patient returns to baseline functioning by the end of 6 months. Theoretically, repeated episodes of schizophreniform illness are possible, each lasting less than 6 months, but rarely is functioning not lost with repeated episodes of this severe illness, and schizophrenia is a more likely consideration.

Ms. L.J. was a 29-year-old Hispanic second daughter of an intact and stable family. She completed high school without problems and was described as outgoing and friendly. She considered college but opted to work. She spent several years as factory worker and had decided to go back to school and become a teacher. Five months ago she had a sudden "awareness" that God was present and filling the souls of people around her. She became acutely distressed when she realized God was not going to "touch her." Her family was quite surprised and alarmed by her sudden change in behavior. She was brought to the local emergency room. While she occasionally drank alcohol and had smoked marijuana in the past, the family did not suspect a substance abuse problem. Toxicology screening in the emergency room was negative for substances. She was admitted to the hospital for evaluation. She told the psychiatrist that she felt she had done something wrong and that was why God had abandoned her. She also reported that she felt people on the ward were reading her mind. She was particularly concerned that her critical thoughts about others could be heard and then these angry people would attack her. L.J. was stabilized on haloperidol then switched to risperidone because of side effects. A family meeting was held to discuss her problems. At that time, the psychiatrist recommended a wait-and-see approach. The psychiatrist told the family and patient to follow up with an outpatient doctor and remain on the medication if the outpatient psychiatrist recommended it. Two months after her admission she no longer was distressed by her religious concerns. However, she still felt people could read her mind. Three months after her admission she no longer felt that people could read her mind, and she had returned to her community college. A month later, she stopped taking her antipsychotic agent because she felt she didn't need it. Two weeks ago her family brought her to the emergency room because she was again talking about God and "hiding" from people who could read her thoughts. She initially refused medications but resumed taking them, with some improvement of her psychosis. A family meeting was held to discuss

the return of her psychosis and the fact that she may eventually be diagnosed with schizophrenia.

Differential Diagnosis

Although the major differential diagnoses are with brief psychotic disorder and schizophrenia, the rapid onset of acute psychosis may be the most important diagnostic point in a patient's course of illness. The clinician should focus on the prior 6 months, taking a detailed history of occupational and social functioning, the pattern of onset, the presence or absence of mood changes, alcohol and substance abuse, and other illness and prescriptive medication. Of special interest will be any family history of psychiatric illness, mood disorders or schizophrenia-like illnesses in particular. A recent study showed a high prevalence of personality disorders after recovery from the psychosis. One could hypothesize that the personality disorder predisposes one to psychosis especially when under stress.

A complete physical examination is always indicated with the presentation of a psychotic illness. Suggestions of endocrinologic involvement, such as thyroid functioning, should be followed up with laboratory studies. If substance abuse is suspected, however remote a possibility, a toxicology screening test should be performed. Changes in sensorium and the rapid onset of symptoms should raise clinical suspicion of substance toxicity. Alcohol may be involved in a number of ways. Certainly, alcohol withdrawal and the onset of delirium may be associated with psychotic symptoms. Further, alcohol abuse leads to unreliable medication taking, even of prescribed medications, which can lead to psychotic features.

The separation of mood disorders with psychotic features from a rapid-onset schizophreniform disorder may be difficult and tests the clinician's skills. Negative symptoms such as alogia, avolition, and blunted affect may be difficult to distinguish from the loss of interest and pleasure seen with major depressive episodes. Appetite, sleep, and other neurovegetative symptoms may also occur with both. The presence of the psychotic features of the illness, in the absence of these mood features, will assist the clinician in making the diagnosis of schizophreniform disorder, but this may take time to evolve.

To differentiate from brief psychotic disorder, a time cutoff has been established, more than 1 day but less than 1 month. During this period, the diagnosis must be brief psychotic disorder. In diagnostic systems prior to DSM-IV, the presence or absence of a stressor was used to differentiate these two conditions further, but it is no longer used in the nosology, except as a descriptor or modifier. Differentiation is based solely on the time line.

Course and Prognosis

The course of schizophreniform disorder is for the most part defined in the criteria. It is a psychotic illness lasting more than 1 month and less than 6 months. The real issue is what happens to persons with this illness over time. Most estimates of progression to schizophrenia range between 60 and 80 percent. What happens to the other 20 to 40 percent is currently not known. Some will have a second or third episode during which they will deteriorate into a more chronic condition of schizophrenia. A few, however, may have only this single episode and then are able to continue on with their lives. While this is clearly the outcome desired by all clinicians and family members, it is probably a rare occurrence and should not be held out as likely.

The prognostic features used to characterize the illness are listed above. Their presence will, indeed, be useful in suggesting some likelihood of a favorable outcome. Clinical experience, however, tempers the confidence in these predictors, as many patients with all four of the descriptors have a deteriorating course and outcome.

Treatment

Although no available studies have directly addressed the treatment of schizophreniform disorder, the approach should be that for any psychotic disorder of recent onset. The most important initial evaluation is safety, both for the patient and the patient's environment.

Safety Assessment of safety or danger is a complex series of probabilities, not certainties. The best predictor is, of course, past behavior. Someone suffering from the sudden onset of psychosis may not have any past history if this is the first episode. If so, any evidence of prior violence must be seriously considered in forming the initial treatment plan. The evaluation of predictability and hostile affect becomes critical in deciding whether hospitalization is necessary. With someone suffering from an acute psychotic disorder who shows any signs of hostility, anger, and confusion or has a history of explosive or violent activity, hospitalization should be an important consideration. In the absence of these features, hospitalization may be a consideration if the environment itself, usually the family, cannot comfortably ensure that the treatment plan can be carried out in a safe, stress-reducing manner. For most families this will not be possible.

Inpatient Treatment Plan The inpatient unit is usually a significant part of the initial treatment plan. In addition to pharmacological management, the unit program and philosophy are critical ingredients in helping to stabilize the patient as rapidly as possible. An environment that is critical, intrusive, and overinvolved, with a multistimulus approach to the patient has negative impact on psychosis-prone patients. With this in mind, the patient should not necessarily be required to attend group meetings, therapeutic community, or orientation but should rather be approached in a one-on-one manner with time-limited interactions. Communication should be direct and simple, and the program should be structured with relatively little free time. Visitors should be oriented to this same principle and should be encouraged to visit one at a time.

Outpatient Treatment Plan The patient who has begun to recover from an acute psychotic episode will continue to need a comfortable environment with considerable structured activity. Complex communications and interactions should be kept to a minimum early, although introduction of some simple group work in an attempt to normalize socialization may be carefully planned. Gradual resumption of activities should be attempted one at a time, with mastery achieved before the introduction of new activities. In the case of a student, for example, it would be much better to begin with one course and succeed than with a full course load that would most likely lead to failure. Incremental progress is the goal, and it should extend well beyond the 6 months required for diagnosis.

Role of the Family There is no more significant factor in the successful outcome of a patient with acute onset psychosis than family involvement in the treatment. As reviewed elsewhere, the data are compelling that a clinical treatment program that enlists the family in a positive clinical alliance does better than one that does not, regardless of the other treatment modalities being used. There is no more consistent finding in outcome studies of the late 1980s and 1990s than the positive outcomes found in programs that work with families. In general, most of these programs begin with some form of educational program about schizophrenia, the importance of medication, the expectations of families, and the identification of early signs of impending relapse. Some of the programs have worked elaborately with patients and their families with behavioral paradigms, others have worked with monthly group interactions involving multiple patients and their families. For many of these families

this introduction to working as a member of the treatment team enlists them into a long-term positive relationship with the treatment program. For others, it gives them the skills needed to participate in the rehabilitation process. This positive alliance will serve the program, the patient, and the family well. It opens lines of communication and takes a major step toward ensuring that the patient will receive the best monitoring and most appropriate treatment available. Active involvement of a family support group, such as the local chapter of the Alliance for the Mentally Ill, is often quite useful as well. Frequently, however, families experiencing their first episode of psychosis in a family member find association with a group of people who have family members with chronic illnesses to be too threatening. They may wish to believe that their family member will recover, and certainly for those who have true schizophreniform disorder, this will be true.

Pharmacological Therapy The pharmacological approach to the acutely psychotic patient is one of the most challenging and difficult in all of psychiatry. There was an era in psychiatry when there was time to observe the patient to determine whether there was a transient condition that would be self-limiting. The economic forces of today's psychiatry do not permit such an observation period and demand vigorous pharmacological intervention. Perhaps the sole remaining condition in which it would be reasonable to wait before vigorous pharmacological intervention is one that elicits a high index of suspicion of chronic amphetamine abuse, with a positive toxicology screening test result. With these patients it is probably better to wait and treat the agitation with benzodiazepines; the psychosis will usually resolve. Even among these patients will be a small but significant group who will continue with what looks like a schizophreniform or schizophrenia-like illness. Whether this group represent a subgroup of patients who were already at risk for schizophrenia or whether chronic amphetamine abuse sensitizes dopamine receptors in some patients is not known. Given that it is not economically feasible to wait before initiating treatment, selection of the most appropriate medication becomes a critical decision. The choices basically come down to selection of an antipsychotic agent. For many years this decision involved selecting the antipsychotic agent whose side-effect profile fit the needs of the patient best. If the patient was agitated, a more sedating antipsychotic agent (e.g., chlorpromazine [Thorazine], thioridazine [Mellaril]) would be selected. If not, a less sedating, high-potency compound would be used (e.g., haloperidol, fluphenazine [Prolixin]). Both strategies, however, exposed the patient to extrapyramidal adverse effects initially and to tardive dyskinesia if long-term continuation was needed. With the use of anticholinergic medications, some of the extrapyramidal symptoms could be reduced. However, anticholinergic medications themselves have been associated with decrements in memory, executive functioning, and new learning. Therefore they are used much less frequently than previously and certainly not used routinely unless adverse effects are present. There are now other choices with the advent of the novel serotonin-dopamine antagonists. These antipsychotic agents, while considerably more expensive, hold out the advantage of fewer extrapyramidal adverse effects. They may rapidly become the medications of first choice for psychosis, because they are much better tolerated by the patient and are thus more likely to be taken over a period of time, eliminating the potential for relapse from noncompliance. The expense of readmission of a patient more than makes up for the difference in cost.

Dosage of any antipsychotic agent should be at the lowest possible level, both for adverse effect prevention and for cost. There is a tendency for medication dosages to climb in an effort to shorten the length of the psychosis. Originally, the concept of "rapid neuroleptization was a method of treatment in which a patient was given

antipsychotic medication every hour until sedated. Thorough evaluation of this strategy revealed no therapeutic advantages and considerably increased risk for acute dystonic reaction. It is now widely accepted that the full resolution of a psychotic episode may take anywhere from 3 to 6 weeks. Pressure to discharge a patient well before this time certainly places considerable psychological pressure on the physician to increase the medication dosage. It is not clear that there is any advantage to doing this, and maintaining a lower dosage keeps the patient considerably less uncomfortable with adverse effects. If agitation is a problem, addition of a medium- to long-acting benzodiazepine will usually produce the desired results.

Benzodiazepines are much better at sedation than are antipsychotic agents. Data suggest that use of a benzodiazepine reduces the amount of an antipsychotic agent that must be used.

A small subgroup of patients present with an acute psychotic episode that rapidly resolves. The more rapid the resolution, the more likely it is that they have a self-limited disorder. These patients will probably not meet the DSM-IV diagnosis of schizophreniform disorder with its requirement of 1 month of symptomatology. For those whose symptoms do last 1 month or longer and who meet the criteria for schizophreniform disorder, there is a question of how long do they need to be on medication. Although no study has directly addressed this question with patients who met DSM-IV criteria for schizophreniform disorder, strategies have been tested on patients with schizophrenia who have been recruited in an acute episode. Patients who were taken off medication in the first 6 months did much worse than those who were maintained at standard dosages or those who had an 80 percent reduction of dosage. Currently, the low-dosage strategy for maintenance should be considered with the standard antipsychotic agents and probably with the serotonin-dopamine antagonists as well.

With the standard antipsychotic agents, a completely resolved psychotic episode, and full return to premorbid functioning, the usual decision point has been 6 months. This time frame was driven by the finding that almost no cases of tardive dyskinesia occur before 6 months of continuous medication. Going beyond 6 months does increase this risk. With the serotonin-dopamine antagonists, tardive dyskinesia is presumed to be a much lower risk if at all, and thus clinical judgment is needed. If a gradual tapering strategy is selected, the dosage should not be lowered more frequently than every 3 to 4 months if the physician wishes to see the effect of one dosage lowering before initiating the next. Unlike antibiotic use, for example, the infection may well return quickly after premature discontinuation of the medication, psychosis does not immediately reappear even if the medication is completely eliminated. Relapse curves from dosage-discontinuation studies are quite compelling in this regard.

BRIEF PSYCHOTIC DISORDER

History

Brief psychotic disorder is a new diagnosis in DSM-IV that subsumes the former diagnostic category of brief reactive psychosis, which first appeared in DSM-II. Brief psychotic disorder is one of the least understood and least studied types of functional psychosis; most research has had methodological flaws and unclear diagnostic criteria. Historically, Karl Jaspers described the concept of a reactive psychosis in 1913. Jaspers described the essential features, which include presence of an identifiable traumatic stressor, close temporal relation between stressor and psychosis, and generally benign course of the psychotic episode.

Jaspers also believed that the content of the psychosis was related to the trauma and served some therapeutic purpose.

Comparative Nosology

Over the past century myriad terms have been used to describe psychotic episodes precipitated by stressful events, including good-prognosis schizophrenia, but brief reactive psychosis had gained prominence until the DSM-IV. Compared with the DSM-III and DSM-III-R criteria that required a precipitating stressor and confusion or emotional turmoil during the episode, the new diagnosis of brief psychotic disorder is less restrictive. With its broader definition, brief psychotic disorder will presumably reduce the use of the classification "psychotic disorder not otherwise specified."

Because stressors and reactions to stressors are so ubiquitous and ill defined, reactivity to a stressor is no longer necessary for the diagnosis and is used instead as a descriptor. Scandinavian researchers have been integral in delineating this disorder, which has been gradually gaining international recognition. Conceptual generalization of the disorder is both supported and challenged by culture-bound syndromes such as koro and amok, which demonstrate significant differences while still falling under the rubric of brief psychotic disorder. The ICD-10 classifies these symptoms as "acute and transient psychotic disorders" (see Table 13.3–1). Subtypes include "acute polymorphic psychotic disorder without symptoms of schizophrenia," which has an overall picture of unstable, highly emotional symptoms with psychotic features that would not justify a diagnosis of schizophrenia. In contrast, the diagnosis acute polymorphic psychotic disorder with symptoms of schizophrenia also describes an unstable clinical picture, but symptoms of schizophrenia are also present for a major part of the time. If the acute picture is marked by delusions, only a diagnosis of "other acute predominately delusional psychotic disorders" can be used. Finally, any unspecified transient psychotic disorder can be designated as other or unspecified acute and transient psychotic disorders.

Epidemiology

Relatively uncommon in DSM field trials, brief psychotic disorder has large discrepancies in reported incidence and prevalence rates because of methodological flaws and diagnostic variability in the literature. Its age of onset is most commonly reported to be in the late 20s or early 30s. Although reliable data on sex and sociocultural determinants are limited, preliminary data suggest a higher incidence in women and persons in developing countries. Such epidemiological patterns are sharply distinct from those of schizophrenia.

Etiology

Little is known about the etiology of brief psychotic disorder. The existence of one or many events becomes the identified causative agent in psychotic disorder with marked stressor (brief reactive psychosis). Both the magnitude and the multiplicity of such stressors are posited to be important, but no well-controlled studies assessing the causal role of various types of stressors are available. Severe intrapsychic conflict (an internal stressor) may be the etiological agent for brief psychotic disorder without a marked stressor. Preexisting characterological psychopathology of either cluster A or B variety may predispose a person to development of the disorder. Many explanatory models of this increased vulnerability exist, but most are based on immature defenses and ego development as major contributors. Family studies support a genetic vulnerability to brief reactive psychosis but do not support a genetic link between this disorder and schizophrenia.

Diagnostic and Clinical Features

The DSM-IV diagnostic criteria are listed in Table 13.1–4. DSM-IV defines brief psychotic disorder as impairment in reality testing lasting at least 1 day but not more than 1 month. An eventual full return to premorbid levels of functioning is required; if

the diagnosis is made without waiting for the anticipated recovery, then the qualifier provision must be added. At least one of the following symptoms is present during the circumscribed illness: delusions, hallucinations, disorganized speech, disorganized behavior, or catatonia. Exclusionary criteria include the presence of a mood disorder with psychotic features, schizoaffective disorder, schizophrenia, and any psychotic disorder secondary to the direct physiological effects of a substance or a general medical condition. If symptoms occur in response to one or more events that would be markedly stressful to almost anyone in similar circumstances and within the same cultural context, then the illness bears the specifier with marked stressor (formerly referred to as brief psychotic disorder). Conversely, if symptoms are not in response to such an event, the specifier without marked stressor is applied. An additional specifier, with postpartum onset, indicates the onset of psychotic symptoms within 4 weeks postpartum.

Table 13.1-4. DSM-IV Diagnostic Criteria for Brief Psychotic Disorder

A. Presence of one (or more) of the following symptoms:

- (1) delusions
- (2) hallucinations
- (3) disorganized speech (e.g., frequent derailment or incoherence)
- (4) grossly disorganized or catatonic behavior

Note: Do not include a symptom if it is a culturally sanctioned response pattern.

B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.

C. The disturbance is not better accounted for by a mood disorder with psychotic features, schizoaffective disorder, or schizophrenia and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With marked stressor(s) (brief reactive psychosis): if symptoms occur shortly after and apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture

Without marked stressor(s): if psychotic symptoms do not occur shortly after, or are not apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture

With postpartum onset: if onset within 4 weeks postpartum

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Patients with brief psychotic disorder typically have rapid-onset psychotic symptomatology and often demonstrate emotional turmoil, confusion, or both. Prompt recovery with a full return to premorbid level of functioning within a month is dictated by definition. It is imperative to assess the impact of culture on symptom presentation prior to making the diagnosis. In the case of brief reactive psychosis, the precipitant may be one or a series of life stressors, such as the loss of an important relationship, familial disruption, or combat-related trauma. In such cases, environmental adversity combines with cultural expectations and support systems to manifest symptoms distinctly.

R.S. was a 44-year-old Haitian male admitted for observation at the local emergency room. He was agitated and combative, requiring restraints and several intramuscular doses of droperidol and lorazepam. The psychiatrist could not interview him under

these acute circumstances. His mother arrived soon after and was able to give corroborative history. According to his mother the patient had just learned that his wife and two children had died in a natural disaster in Haiti. Several hours after his first evaluation, the patient was calmer. He told staff that he was hearing his wife talking to him and he wished to "join her." He also believed the Haitian secret police were coming to arrest him. He was admitted to the inpatient ward and began a course of an antipsychotic agent. By the third day of his hospitalization there was no evidence of the previous psychosis. He was discharged from the hospital and given a follow-up appointment in 1 month. When he returned the next month he had been medication free for that time. He was grieving the loss of his family but was not psychotic. He was referred to a grief group, which he attended for the next 6 months. In that time he remained sad, but there were no other episodes of paranoia or hallucinations.

Differential Diagnosis

Sharing rapid onset of symptoms, brief psychotic disorder must be differentiated from substance-induced psychotic disorders and psychotic disorders due to a general medical condition. A thorough medical evaluation including a physical examination, laboratory studies, and brain imaging will help rule out many of those conditions. With only cross-sectional information, brief psychotic disorder is difficult to differentiate from other types of functional psychosis.

The relationship between brief psychotic disorder and both schizophrenia and affective disorders remains uncertain. As noted above, DSM-IV has made the distinction between brief psychotic disorder and schizophreniform disorder clearer by now requiring a full month of psychotic symptoms for the latter. If psychotic symptoms are present longer than 1 month, the diagnoses of schizophreniform disorder, schizoaffective disorder, schizophrenia, mood disorders with psychotic features, delusional disorder, and psychotic disorder not otherwise specified need to be entertained. If psychotic symptoms of sudden onset are present for less than a month in response to an obvious stressor, the diagnosis of brief psychotic disorder is strongly suggested. Other diagnoses to differentiate include factitious disorder, malingering, and severe personality disorders, with consequent transient psychosis possible.

Course and Prognosis

The course of brief psychotic disorder is found in the diagnostic criteria of DSM-IV. It is a psychotic episode that lasts more than 1 day but less than 1 month, with eventual return to premorbid level of functioning. Approximately half of patients diagnosed with brief psychotic disorder retain this diagnosis; the other half will evolve into either schizophrenia or a major affective disorder. There are no apparent distinguishing features between brief psychotic disorder, acute-onset schizophrenia, and mood disorders with psychotic features on initial presentation. Several prognostic features have been proposed to characterize the illness, but they are inconsistent across studies. The good prognostic features are similar to those found in schizophreniform disorder: acute onset of psychotic symptoms, confusion or emotional turmoil at the height of the psychotic episode, good premorbid functioning, the presence of affective symptoms, and short duration of symptoms. There is a relative dearth of information on the recurrence of brief psychotic episodes, however, so the course and prognosis of this disorder have not been well characterized.

Treatment

Although no available studies directly address the treatment of brief psychotic disorder, the treatment approach should focus on the acute onset of psychotic

symptoms. In particular, patient safety is of paramount importance. Depending on the danger the patient represents to self and others, psychiatric hospitalization is often warranted. A patient demonstrating acute psychotic symptoms who also displays a hostile affect or has a history of violence is particularly likely to require hospitalization. In addition to providing a safe and structured environment, hospitalization permits observational monitoring and a medical examination investigating potential etiological factors.

If medication is necessary, a high-potency antipsychotic agent in low dosage is typically recommended. An antiparkinsonism agent may be added if extrapyramidal adverse effects occur. A benzodiazepine used in combination with an antipsychotic agent can act synergistically, thereby lowering the necessary doses of each and reducing the risk of side effects. Benzodiazepines can also be used as monotherapy to reduce agitation without obscuring the clinical picture. The role of other psychotropic medications such as mood stabilizers and antidepressants is not yet clear.

After the acute episode has subsided, long-term treatment is required. An individualized treatment strategy based on increasing problem-solving skills while strengthening the ego structure through psychotherapy, appears to be the most efficacious. Involvement of the family in the treatment process is crucial to a successful outcome and is reviewed elsewhere in this chapter. There is no role for maintenance antipsychotic treatment in brief psychotic disorder; if such treatment is required, the diagnostic assumptions must be questioned.